Welcome to

JWCHIROPRACTIC

115 West 45th Street, Suite 301 | New York, NY 10036
Phone: 212.922.9200 | Fax: 212.922.9553

Patient information (please print):

FIRST NAME ____________________ LAST NAME ____________________ DATE____________________

ADDRESS ____________________ APT __________ CITY ______________ STATE__________ ZIP ___________

HOME PHONE ( )______________ CELL ( )________________ EMAIL ____________________

MARITAL STATUS: ☐ Married ☐ Single ☐ Divorced ☐ Widowed GENDER ☐ Male ☐ Female

AGE _______ DATE OF BIRTH _________ # OF CHILDREN _________ SOC SEC # ____________________

OCCUPATION ____________________ EMPLOYER ____________________

ADDRESS ____________________CITY__________ STATE___ ZIP ___________ PHONE ( )__________

HOW DID YOU HEAR ABOUT THIS OFFICE? ____________________

Patient Condition:

HAVE YOU HAD CHIROPRACTIC CARE BEFORE? ☐ NO ☐ YES WHEN? ____________ Dr. ____________________

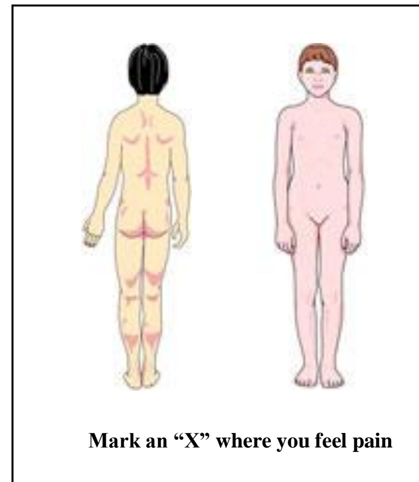
DESCRIBE YOUR SYMPTOMS: ____________________

IS THE CONDITION GETTING PROGRESSIVELY WORSE? ☐ NO ☐YES ☐ I DON'T KNOW

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? (Please list) ____________________

WHAT TYPE OF PAIN ARE YOU EXPERIENCING?

☐ **Sharp** ☐ **Dull** ☐ **Throbbing**
☐ **Aching** ☐ **Stiffness** ☐ **Tingling**
☐ **Numbness** ☐ **Shooting** ☐ **Other:** _______



Mark an "X" where you feel pain

HOW OFTEN DO YOU EXPERIENCE YOUR SYMPTOMS?

☐ **Constantly** (76-100%) ☐ **Frequently** (51-75%)
☐ **Occasionally** (26-50%) ☐ **Intermittently** (0-25%)

RATE YOUR PAIN ON A SCALE FROM 0-10? (Please circle)

0 1 2 3 4 5 6 7 8 9 10

(no pain) *(moderate pain)* *(severe pain)*

WHAT ACTIVITIES MAKE YOUR SYMPTOMS ***WORSE***?

☐ **Sitting** ☐ **Standing** ☐ **Walking** ☐ **Bending** ☐ **Lifting** ☐ **Lying Down** ☐ **Other**____________________

WHAT ACTIVITES MAKE YOUR SYMPTOMS ***BETTER***?

☐ **Sitting** ☐ **Standing** ☐ **Walking** ☐ **Bending** ☐ **Lifting** ☐ **Lying Down** ☐ **Other**____________________

HAVE YOU HAD SIMILAR SYMPTONS IN THE PAST? ☐ NO ☐ YES (Please explain) ____________________

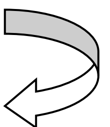
WHAT KIND OF WORK ACTIVITIES DO YOU PERFORM?

☐ **Sitting** ☐ **Standing** ☐ **Light Labor** ☐ **Heavy Labor**

HOW OFTEN DO YOU EXERCISE?

☐ **None** ☐ **Light** ☐ **Moderate** ☐ **Daily** ☐ **Heavy**

Turn over for page 2



Health History:

HAVE YOU EVER SUFFERED FROM ANY OF THE FOLLOWING? (Please circle all that apply)

☐ **AIDS/HIV** ☐ **Anemia** ☐ **Arthritis** ☐ **Asthma** ☐ **Bleeding Disorders** ☐ **Breast Lumps**
☐ **Cancer** ☐ **Diabetes** ☐ **Epilepsy** ☐ **Gout** ☐ **Heart Disease** ☐ **Kidney Disease**
☐ **Dizziness** ☐ **Stroke** ☐ **Headaches** ☐ **Tumors** ☐ **Osteoporosis** ☐ **Pacemaker**
☐ **Prostate problems** ☐ **High Blood Pressure** ☐ **Digestive disorders** ☐ **Other** ___________________________

PLEASE LIST ANY PREVIOUS INJURIES OR SURGERIES:____

ARE YOU PREGNANT? (**For women only**) ☐ NO ☐ YES If yes, how long? ____

Insurance Information:

DO YOU HAVE HEALTH INSURANCE? ☐ NO ☐ YES
(If yes, please complete the following and provide us your insurance card so we can make a copy for our records)

NAME OF INSURANCE COMPANY(S) ____

GROUP # ____ MEMBER ID # ____

PLEASE COMPLETE THIS SECTION ONLY IF YOUR CONDITION IS THE RESULT OF AN ACCIDENT

Please check one: ☐ Auto Accident ☐ Work Accident ☐ Other ___________Date of injury ________________ Time __________

How did the accident occur? ____

Did you report your injury? ☐ NO ☐ YES To whom? ____

Did you go to the hospital? ☐ NO ☐ YES Which hospital? ____

By Ambulance? ☐ NO ☐ YES X-rays taken? ☐ NO ☐ YES By Whom? ____________________________

Date(s) of hospitalization ______________________ Medication prescribed _______________________________________

Are you currently working? ☐ NO ☐ YES Date you last worked ____

Have you been treated by any other doctor for this injury? ☐ NO ☐ YES By whom? ___________________________________

ASSIGNMENT OF BENEFITS AND POWER OF ATTORNEY TO CASH CHECKS

I, the undersigned, do hereby authorize payment directly to the office above, the benefits of my coverage, if any, otherwise payable to me for services but not to exceed the customary charge for those services. I understand that I am financially responsible for all charges whether or not paid by insurance. If these payments are made out to me I grant unto the office below as attorney the full power and authority in my name and stead to endorse any and all checks and drafts or money orders. I hereby authorize the doctor to release all information necessary to secure payment of benefits. A photocopy of this assignment shall be valid.

Date: _______________________________ Patient's Signature ____

AUTO AND OTHER ACCIDENTS – NOTICE OF LIEN TO ATTORNEY

I, the undersigned, hereby authorize and direct you, my attorney, to pay directly to **JW Chiropractic, PLLC** such sums as may be due and owing him for medical service rendered me both by reason of this accident and by reason of any other bills that are due his office and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect said doctor. And I hereby further give a lien on my case to said doctor against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney or myself as the result of the injuries for which I have been treated or injuries in connection therewith. I agree never to rescind this document and that a rescission will not be honored by my attorney. I hereby instruct that in the event another attorney is substituted in this matter, the new attorney honor this lien as inherent to the settlement and enforceable upon the case as if it were execute by him. I further agree that in the event this lien is litigated that in the prevailing party will be awarded attorney fees and costs.

Date: _______________________________ Patient's Signature ____